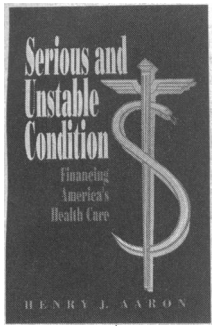
Power groups feel the pinch



Serious and Unstable Condition: Financing America's Health Care.
H J Aaron.
(Pp 158; $22.95.)
Brookings Institution, 1991.
Available from Brookings Institution, 1775 Massachusetts Avenue, NW, Washington, DC 20036, USA.
ISBN 0-8157-0051-2.

While health care systems in Europe adopt market approaches, in America more intervention is proposed. This is odd given the worldwide movement towards markets. Why is this? It seems that the market disciplines that European systems lacked the American health system has in excess.

In the United States many millions are denied the security of health care cover, and Medicare and Medicaid—introduced nearly 30 years ago—are under strain. But the needs of the poor and uninsured are not the main reason for the increasing calls for change. It is the rising costs that burden industry, make increasing demands on public funds, and challenge the viability of insurance companies that underlie the calls for change.

The system has survived because it satisfied the power groups. The insured were content with their care; industry saw health insurance as a cheap way of attracting and retaining staff; insurance companies found a secure base in corporate insurance; and providers and professionals were happy with a system that allowed them to provide services and retrospectively claim reimbursement. Tighter economic conditions and accelerating costs changed all this.

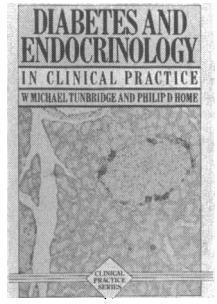
Aaron describes the limitations of markets and shows how self interested market behaviour in the American system has rooted out altruism. "Community rating," which allowed high risk people to obtain insurance cover, has been replaced by "risk related" premiums. Reimbursement systems now allow little scope for hospitals to care for those who cannot pay, as better information systems increase the visibility of such practices and greater competition makes them non-viable. Yet the removal of such loopholes has strengthened the case for market intervention.

Along with demographic pressures and new technology it is "supplier induced demand"—demand generated by professionals motivated by self interest—that is believed to cause rising costs. In America and elsewhere doctors are seen as the "enemy within," distorting demand and using resources on treatment of unproved effectiveness. Increasingly policies are being developed to control their practice.

Aaron considers that problems of equity, efficiency, and effectiveness can simultaneously be remedied by his plan. In a scheme reminiscent of the provider markets of the reformed NHS he proposes universal access, administered by a single buyer responsible for a fixed budget and empowered to set fees and priorities and monitor effectiveness, so modifying demands generated by consumers and doctors.

Forces that lead to radical change in health care systems rarely coalesce, and though Aaron might be correct in seeing the present circumstances as propitious, he does not convince me that there is political will to change or that vested interest groups would support his plan. He does provide information, clear analysis, and historical insight.—J A ROBERTS, *senior lecturer in health economics, London School of Hygiene and Tropical Medicine*

Not all the questions



Diabetes and Endocrinology in Clinical Practice.
W M Tunbridge, P D Home.
(Pp 324; £29.50.)
Sevenoaks, Kent: Hodder and Stoughton, 1991.
ISBN 0-340-545615.

Aimed particularly at candidates for the MRCP(UK), the book has only partially realised the opportunity to discuss a fascinating aspect of British clinical service arising because diabetes mellitus has, through financial stringency and the national shortage of doctors, emerged as ripe for new management. Doctors have always sought to make the competent minority of even their insulin treated patients short term managers of their own disease; so should not nurse advisers be useful in advising patients, according to what they have learnt in their turn from specialised nurses and doctors?

The first straightforwardly valuable chapters on diabetes discuss aetiology, definition, pathogenesis, and tissue damage. After a helpful section on the targets that patients should adopt for their treatment the "core services" are described, mostly from the viewpoint of hospital doctors responsible for all the diabetic services for a whole population. This reversal of the basic NHS constitution (in which the general practitioner decided where and by whom his or her patients should be cared for) probably inevitably followed the frequent abrogation by general practitioners to clinic staff of much non-glycaemic and even non-diabetic care of their diabetic patients. It is something many general practitioners are now keen to reverse, certainly for non-insulin treated patients but even for many of the insulin treated. All too little of the ferment of this vigorous debate emerges here (perhaps because of the artificiality of the MRCP exam).

The essential measure to assess the worth of the new changes is diabetic audit. I have some inevitable qualms over detail: at annual review in Newcastle diarrhoea is not considered in a population liable to autonomic neuropathy and preprandial treatment with metformin; no thought among the joint clinics for those with renal failure or the impotent; but, most disappointingly, a lack of integration of knowledge to face up to the different nature of the relation between glycaemic level and severity of damage to the microvessels and macrovessels respectively. This last omission perhaps allows evasion of the great importance of microalbuminuria as a pointer to future cardiovascular disease. In general the diabetic section tends to be weak on treatment of the manifestations of tissue damage.

After consideration of a "diabetic service" it is disappointing that the long term follow up of patients with autoimmune thyroiditis (whether with an overactive or underactive thyroid gland) is not discussed, however briefly. After all, hypothyroidism with full exogenous hormone replacement is the only certainly stable state. It is not enough under clinical features of hypothyroidism to tuck away "ataxia" among seven other neurological features without emphasising that it is truncal and frequent, at least symptomatically as the patient walks; it does not usually affect the arms and legs.

Perhaps also reflecting infrequency in clinical practice, non-pigmentary chronic Addison's disease is not mentioned, but gonadal diseases receive only 20 pages (against 158 for diabetes) with no clear definition of virilisation, no mention of clitoromegaly in that regard, and no mention of glucose intolerance in connection with polycystic ovaries.

This is a clearly presented book, which contains a wealth of information organised more from the viewpoint of disease entities than patients' troubles. The discussion of a diabetic service is a valuable approach to a currently important topic but avoids some of the knottier issues.—T D R HOCKADAY, *consultant physician, Radcliffe Infirmary, Oxford*

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